

**ASSEMBLY BILL**

**No. 1424**

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**Introduced by Assembly Member Achadjian**

February 27, 2015

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An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1424, as introduced, Achadjian. Medi-Cal: benefits.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits provided under the Medi-Cal program, which includes specified outpatient services and inpatient hospital services, subject to utilization controls.

This bill would make technical, nonsubstantive changes to these provisions.

Vote: majority. Appropriation: no. Fiscal committee: no.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 14132 of the Welfare and Institutions
- 2 Code is amended to read:
- 3 14132. The following is the schedule of benefits under this
- 4 chapter:
- 5 (a) Outpatient services are covered as follows:

1 Physician, hospital or clinic outpatient, surgical center,  
2 respiratory care, optometric, chiropractic, psychology, podiatric,  
3 occupational therapy, physical therapy, speech therapy, audiology,  
4 acupuncture to the extent federal matching funds are provided for  
5 acupuncture, and services of persons rendering treatment by prayer  
6 or healing by spiritual means in the practice of any church or  
7 religious denomination insofar as these can be encompassed by  
8 federal participation under an approved plan, subject to utilization  
9 controls.

10 (b) (1) Inpatient hospital services, including, but not limited  
11 to, physician and podiatric services, ~~physical therapy~~ *therapy*, and  
12 occupational therapy, are covered subject to utilization controls.

13 (2) For Medi-Cal fee-for-service beneficiaries, emergency  
14 services and care that are necessary for the treatment of an  
15 emergency medical condition and medical care directly related to  
16 the emergency medical condition. This paragraph shall not be  
17 construed to change the obligation of Medi-Cal managed care  
18 plans to provide emergency services and care. For the purposes of  
19 this paragraph, “emergency services and care” and “emergency  
20 medical condition” shall have the same meanings as those terms  
21 are defined in Section 1317.1 of the Health and Safety Code.

22 (c) Nursing facility services, subacute care services, and services  
23 provided by any category of intermediate care facility for the  
24 developmentally disabled, including podiatry, physician, nurse  
25 practitioner services, and prescribed drugs, as described in  
26 subdivision (d), are covered subject to utilization controls.  
27 Respiratory care, physical therapy, occupational therapy, speech  
28 therapy, and audiology services for patients in nursing facilities  
29 and any category of intermediate care facility for the  
30 developmentally disabled are covered subject to utilization controls.

31 (d) (1) Purchase of prescribed drugs is covered subject to the  
32 Medi-Cal List of Contract Drugs and utilization controls.

33 (2) Purchase of drugs used to treat erectile dysfunction or any  
34 off-label uses of those drugs are covered only to the extent that  
35 federal financial participation is available.

36 (3) (A) To the extent required by federal law, the purchase of  
37 outpatient prescribed drugs, for which the prescription is executed  
38 by a prescriber in written, nonelectronic form on or after April 1,  
39 2008, is covered only when executed on a tamper resistant  
40 prescription form. The implementation of this paragraph shall

1 conform to the guidance issued by the federal Centers for Medicare  
2 and Medicaid Services but shall not conflict with state statutes on  
3 the characteristics of tamper resistant prescriptions for controlled  
4 substances, including Section 11162.1 of the Health and Safety  
5 Code. The department shall provide providers and beneficiaries  
6 with as much flexibility in implementing these rules as allowed  
7 by the federal government. The department shall notify and consult  
8 with appropriate stakeholders in implementing, interpreting, or  
9 making specific this paragraph.

10 (B) Notwithstanding Chapter 3.5 (commencing with Section  
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
12 the department may take the actions specified in subparagraph (A)  
13 by means of a provider bulletin or notice, policy letter, or other  
14 similar instructions without taking regulatory action.

15 (4) (A) (i) For the purposes of this paragraph, nonlegend has  
16 the same meaning as defined in subdivision (a) of Section  
17 14105.45.

18 (ii) Nonlegend acetaminophen-containing products, with the  
19 exception of children's acetaminophen-containing products,  
20 selected by the department are not covered benefits.

21 (iii) Nonlegend cough and cold products selected by the  
22 department are not covered benefits. This clause shall be  
23 implemented on the first day of the first calendar month following  
24 90 days after the effective date of the act that added this clause,  
25 or on the first day of the first calendar month following 60 days  
26 after the date the department secures all necessary federal approvals  
27 to implement this section, whichever is later.

28 (iv) Beneficiaries under the Early and Periodic Screening,  
29 Diagnosis, and Treatment Program shall be exempt from clauses  
30 (ii) and (iii).

31 (B) Notwithstanding Chapter 3.5 (commencing with Section  
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
33 the department may take the actions specified in subparagraph (A)  
34 by means of a provider bulletin or notice, policy letter, or other  
35 similar instruction without taking regulatory action.

36 (e) Outpatient dialysis services and home hemodialysis services,  
37 including physician services, medical supplies, drugs and  
38 equipment required for dialysis, are covered, subject to utilization  
39 controls.

1 (f) Anesthesiologist services when provided as part of an  
2 outpatient medical procedure, nurse anesthetist services when  
3 rendered in an inpatient or outpatient setting under conditions set  
4 forth by the director, outpatient laboratory services, and X-ray  
5 services are covered, subject to utilization controls. ~~Nothing in~~  
6 ~~this~~ This subdivision shall *not* be construed to require prior  
7 authorization for anesthesiologist services provided as part of an  
8 outpatient medical procedure or for portable X-ray services in a  
9 nursing facility or any category of intermediate care facility for  
10 the developmentally disabled.

11 (g) Blood and blood derivatives are covered.

12 (h) (1) Emergency and essential diagnostic and restorative  
13 dental services, except for orthodontic, fixed bridgework, and  
14 partial dentures that are not necessary for balance of a complete  
15 artificial denture, are covered, subject to utilization controls. The  
16 utilization controls shall allow emergency and essential diagnostic  
17 and restorative dental services and prostheses that are necessary  
18 to prevent a significant disability or to replace previously furnished  
19 prostheses which are lost or destroyed due to circumstances beyond  
20 the beneficiary's control. Notwithstanding the foregoing, the  
21 director ~~may by regulation~~ *may, by regulation*, provide for certain  
22 fixed artificial dentures necessary for obtaining employment or  
23 for medical conditions that preclude the use of removable dental  
24 prostheses, and for orthodontic services in cleft palate deformities  
25 administered by the department's California Children Services  
26 Program.

27 (2) For persons 21 years of age or older, the services specified  
28 in paragraph (1) shall be provided subject to the following  
29 conditions:

30 (A) Periodontal treatment is not a benefit.

31 (B) Endodontic therapy is not a benefit except for vital  
32 pulpotomy.

33 (C) Laboratory processed crowns are not a benefit.

34 (D) Removable prosthetics shall be a benefit only for patients  
35 as a requirement for employment.

36 (E) The director may, by regulation, provide for the provision  
37 of fixed artificial dentures that are necessary for medical conditions  
38 that preclude the use of removable dental prostheses.

1 (F) Notwithstanding the conditions specified in subparagraphs  
2 (A) to (E), inclusive, the department may approve services for  
3 persons with special medical disorders subject to utilization review.

4 (3) Paragraph (2) shall become inoperative July 1, 1995.

5 (i) Medical transportation is covered, subject to utilization  
6 controls.

7 (j) Home health care services are covered, subject to utilization  
8 controls.

9 (k) Prosthetic and orthotic devices and eyeglasses are covered,  
10 subject to utilization controls. Utilization controls shall allow  
11 replacement of prosthetic and orthotic devices and eyeglasses  
12 necessary because of loss or destruction due to circumstances  
13 beyond the beneficiary's control. Frame styles for eyeglasses  
14 replaced pursuant to this subdivision shall not change more than  
15 once every two years, unless the department so directs.

16 Orthopedic and conventional shoes are covered when provided  
17 by a prosthetic and orthotic supplier on the prescription of a  
18 physician and when at least one of the shoes will be attached to a  
19 prosthesis or brace, subject to utilization controls. Modification  
20 of stock conventional or orthopedic shoes when medically  
21 indicated, is covered subject to utilization controls. When there is  
22 a clearly established medical need that cannot be satisfied by the  
23 modification of stock conventional or orthopedic shoes,  
24 custom-made orthopedic shoes are covered, subject to utilization  
25 controls.

26 Therapeutic shoes and inserts are covered when provided to  
27 beneficiaries with a diagnosis of diabetes, subject to utilization  
28 controls, to the extent that federal financial participation is  
29 available.

30 (l) Hearing aids are covered, subject to utilization controls.  
31 Utilization controls shall allow replacement of hearing aids  
32 necessary because of loss or destruction due to circumstances  
33 beyond the beneficiary's control.

34 (m) Durable medical equipment and medical supplies are  
35 covered, subject to utilization controls. The utilization controls  
36 shall allow the replacement of durable medical equipment and  
37 medical supplies when necessary because of loss or destruction  
38 due to circumstances beyond the beneficiary's control. The  
39 utilization controls shall allow authorization of durable medical  
40 equipment needed to assist a disabled beneficiary in caring for a

1 child for whom the disabled beneficiary is a parent, stepparent,  
2 foster parent, or legal guardian, subject to the availability of federal  
3 financial participation. The department shall adopt emergency  
4 regulations to define and establish criteria for assistive durable  
5 medical equipment in accordance with the rulemaking provisions  
6 of the Administrative Procedure Act (Chapter 3.5 (commencing  
7 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
8 Government Code).

9 (n) Family planning services are covered, subject to utilization  
10 controls. However, for Medi-Cal managed care plans, any  
11 utilization controls shall be subject to Section 1367.25 of the Health  
12 and Safety Code.

13 (o) Inpatient intensive rehabilitation hospital services, including  
14 respiratory rehabilitation services, in a general acute care hospital  
15 are covered, subject to utilization controls, when either of the  
16 following criteria are met:

17 (1) A patient with a permanent disability or severe impairment  
18 requires an inpatient intensive rehabilitation hospital program as  
19 described in Section 14064 to develop function beyond the limited  
20 amount that would occur in the normal course of recovery.

21 (2) A patient with a chronic or progressive disease requires an  
22 inpatient intensive rehabilitation hospital program as described in  
23 Section 14064 to maintain the patient's present functional level as  
24 long as possible.

25 (p) (1) Adult day health care is covered in accordance with  
26 Chapter 8.7 (commencing with Section 14520).

27 (2) Commencing 30 days after the effective date of the act that  
28 added this paragraph, and notwithstanding the number of days  
29 previously approved through a treatment authorization request,  
30 adult day health care is covered for a maximum of three days per  
31 week.

32 (3) As provided in accordance with paragraph (4), adult day  
33 health care is covered for a maximum of five days per week.

34 (4) As of the date that the director makes the declaration  
35 described in subdivision (g) of Section 14525.1, paragraph (2)  
36 shall become inoperative and paragraph (3) shall become operative.

37 (q) (1) Application of fluoride, or other appropriate fluoride  
38 treatment as defined by the department, and other prophylaxis  
39 treatment for children 17 years of age and under are covered.

1 (2) All dental hygiene services provided by a registered dental  
2 hygienist, registered dental hygienist in extended functions, and  
3 registered dental hygienist in alternative practice licensed pursuant  
4 to Sections 1753, 1917, 1918, and 1922 of the Business and  
5 Professions Code may be covered as long as they are within the  
6 scope of Denti-Cal benefits and they are necessary services  
7 provided by a registered dental hygienist, registered dental  
8 hygienist in extended functions, or registered dental hygienist in  
9 alternative practice.

10 (r) (1) Paramedic services performed by a city, county, or  
11 special district, or pursuant to a contract with a city, county, or  
12 special district, and pursuant to a program established under Article  
13 3 (commencing with Section 1480) of Chapter 2.5 of Division 2  
14 of the Health and Safety Code by a paramedic certified pursuant  
15 to that article, and consisting of defibrillation and those services  
16 specified in subdivision (3) of Section 1482 of the article.

17 (2) All providers enrolled under this subdivision shall satisfy  
18 all applicable statutory and regulatory requirements for becoming  
19 a Medi-Cal provider.

20 (3) This subdivision shall be implemented only to the extent  
21 funding is available under Section 14106.6.

22 (s) In-home medical care services are covered when medically  
23 appropriate and subject to utilization controls, for beneficiaries  
24 who would otherwise require care for an extended period of time  
25 in an acute care hospital at a cost higher than in-home medical  
26 care services. The director shall have the authority under this  
27 section to contract with organizations qualified to provide in-home  
28 medical care services to those persons. These services may be  
29 provided to patients placed in shared or congregate living  
30 arrangements, if a home setting is not medically appropriate or  
31 available to the beneficiary. As used in this section, “in-home  
32 medical care service” includes utility bills directly attributable to  
33 continuous, 24-hour operation of life-sustaining medical equipment,  
34 to the extent that federal financial participation is available.

35 As used in this subdivision, in-home medical care services  
36 include, but are not limited to:

- 37 (1) Level-of-care and cost-of-care evaluations.
- 38 (2) Expenses, directly attributable to home care activities, for  
39 materials.
- 40 (3) Physician fees for home visits.

- 1 (4) Expenses directly attributable to home care activities for  
2 shelter and modification to shelter.
- 3 (5) Expenses directly attributable to additional costs of special  
4 diets, including tube feeding.
- 5 (6) Medically related personal services.
- 6 (7) Home nursing education.
- 7 (8) Emergency maintenance repair.
- 8 (9) Home health agency personnel benefits which permit  
9 coverage of care during periods when regular personnel are on  
10 vacation or using sick leave.
- 11 (10) All services needed to maintain antiseptic conditions at  
12 stoma or shunt sites on the body.
- 13 (11) Emergency and nonemergency medical transportation.
- 14 (12) Medical supplies.
- 15 (13) Medical equipment, including, but not limited to, scales,  
16 gurneys, and equipment racks suitable for paralyzed patients.
- 17 (14) Utility use directly attributable to the requirements of home  
18 care activities which are in addition to normal utility use.
- 19 (15) Special drugs and medications.
- 20 (16) Home health agency supervision of visiting staff which is  
21 medically necessary, but not included in the home health agency  
22 rate.
- 23 (17) Therapy services.
- 24 (18) Household appliances and household utensil costs directly  
25 attributable to home care activities.
- 26 (19) Modification of medical equipment for home use.
- 27 (20) Training and orientation for use of life-support systems,  
28 including, but not limited to, support of respiratory functions.
- 29 (21) Respiratory care practitioner services as defined in Sections  
30 3702 and 3703 of the Business and Professions Code, subject to  
31 prescription by a physician and surgeon.
- 32 Beneficiaries receiving in-home medical care services are entitled  
33 to the full range of services within the Medi-Cal scope of benefits  
34 as defined by this section, subject to medical necessity and  
35 applicable utilization control. Services provided pursuant to this  
36 subdivision, which are not otherwise included in the Medi-Cal  
37 schedule of benefits, shall be available only to the extent that  
38 federal financial participation for these services is available in  
39 accordance with a home- and community-based services waiver.

1 (t) Home- and community-based services approved by the  
2 United States Department of Health and Human Services are  
3 covered to the extent that federal financial participation is available  
4 for those services under the state plan or waivers granted in  
5 accordance with Section 1315 or 1396n of Title 42 of the United  
6 States Code. The director may seek waivers for any or all home-  
7 and community-based services approvable under Section 1315 or  
8 1396n of Title 42 of the United States Code. Coverage for those  
9 services shall be limited by the terms, conditions, and duration of  
10 the federal waivers.

11 (u) Comprehensive perinatal services, as provided through an  
12 agreement with a health care provider designated in Section  
13 14134.5 and meeting the standards developed by the department  
14 pursuant to Section 14134.5, subject to utilization controls.

15 The department shall seek any federal waivers necessary to  
16 implement ~~the provisions of~~ this subdivision. The provisions for  
17 which appropriate federal waivers cannot be obtained shall not be  
18 implemented. Provisions for which waivers are obtained or for  
19 which waivers are not required shall be implemented  
20 notwithstanding any inability to obtain federal waivers for the  
21 other provisions. ~~No provision of this~~ *This* subdivision shall *not*  
22 be implemented unless matching funds from Subchapter XIX  
23 (commencing with Section 1396) of Chapter 7 of Title 42 of the  
24 United States Code are available.

25 (v) Early and periodic screening, diagnosis, and treatment for  
26 any individual under 21 years of age is covered, consistent with  
27 the requirements of Subchapter XIX (commencing with Section  
28 1396) of Chapter 7 of Title 42 of the United States Code.

29 (w) Hospice service ~~which~~ *that* is Medicare-certified hospice  
30 service is covered, subject to utilization controls. Coverage shall  
31 be available only to the extent that no additional net program costs  
32 are incurred.

33 (x) When a claim for treatment provided to a beneficiary  
34 includes both services which are authorized and reimbursable  
35 under this chapter, and services which are not reimbursable under  
36 this chapter, that portion of the claim for the treatment and services  
37 authorized and reimbursable under this chapter shall be payable.

38 (y) Home- and community-based services approved by the  
39 United States Department of Health and Human Services for

1 beneficiaries with a diagnosis of AIDS or ARC, who require  
2 intermediate care or a higher level of care.

3 Services provided pursuant to a waiver obtained from the  
4 Secretary of the United States Department of Health and Human  
5 Services pursuant to this subdivision, and which are not otherwise  
6 included in the Medi-Cal schedule of benefits, shall be available  
7 only to the extent that federal financial participation for these  
8 services is available in accordance with the waiver, and subject to  
9 the terms, conditions, and duration of the waiver. These services  
10 shall be provided to individual beneficiaries in accordance with  
11 the client's needs as identified in the plan of care, and subject to  
12 medical necessity and applicable utilization control.

13 The director ~~may~~ *may*, under this ~~section~~ *section*, contract with  
14 organizations qualified to provide, directly or by subcontract,  
15 services provided for in this subdivision to eligible beneficiaries.  
16 Contracts or agreements entered into pursuant to this division shall  
17 not be subject to the Public Contract Code.

18 (z) Respiratory care when provided in organized health care  
19 systems as defined in Section 3701 of the Business and Professions  
20 Code, and as an in-home medical service as outlined in subdivision  
21 (s).

22 (aa) (1) There is hereby established in the department, a  
23 program to provide comprehensive clinical family planning  
24 services to any person who has a family income at or below 200  
25 percent of the federal poverty level, as revised annually, and who  
26 is eligible to receive these services pursuant to the waiver identified  
27 in paragraph (2). This program shall be known as the Family  
28 Planning, Access, Care, and Treatment (Family PACT) Program.

29 (2) The department shall seek a waiver in accordance with  
30 Section 1315 of Title 42 of the United States Code, or a state plan  
31 amendment adopted in accordance with Section  
32 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States  
33 Code, which was added to Section 1396a of Title 42 of the United States  
34 Code by Section 2303(a)(2) of the federal Patient Protection and  
35 Affordable Care Act (PPACA) (Public Law 111-148), for a  
36 program to provide comprehensive clinical family planning  
37 services as described in paragraph (8). Under the waiver, the  
38 program shall be operated only in accordance with the waiver and  
39 the statutes and regulations in paragraph (4) and subject to the  
40 terms, conditions, and duration of the waiver. Under the state plan

1 amendment, which shall replace the waiver and shall be known as  
2 the Family PACT successor state plan amendment, the program  
3 shall be operated only in accordance with this subdivision and the  
4 statutes and regulations in paragraph (4). The state shall use the  
5 standards and processes imposed by the state on January 1, 2007,  
6 including the application of an eligibility discount factor to the  
7 extent required by the federal Centers for Medicare and Medicaid  
8 Services, for purposes of determining eligibility as permitted under  
9 Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States  
10 Code. To the extent that federal financial participation is available,  
11 the program shall continue to conduct education, outreach,  
12 enrollment, service delivery, and evaluation services as specified  
13 under the waiver. The services shall be provided under the program  
14 only if the waiver and, when applicable, the successor state plan  
15 amendment are approved by the federal Centers for Medicare and  
16 Medicaid Services and only to the extent that federal financial  
17 participation is available for the services. ~~Nothing in this~~ *This*  
18 section shall *not* prohibit the department from seeking the Family  
19 PACT successor state plan amendment during the operation of the  
20 waiver.

21 (3) Solely for the purposes of the waiver or Family PACT  
22 successor state plan amendment and notwithstanding any other  
23 ~~provision of~~ law, the collection and use of an individual's social  
24 security number shall be necessary only to the extent required by  
25 federal law.

26 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,  
27 and 24013, and any regulations adopted under these statutes shall  
28 apply to the program provided for under this subdivision. No other  
29 ~~provision of~~ law under the Medi-Cal program or the State-Only  
30 Family Planning Program shall apply to the program provided for  
31 under this subdivision.

32 (5) Notwithstanding Chapter 3.5 (commencing with Section  
33 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
34 the department may implement, without taking regulatory action,  
35 the provisions of the waiver after its approval by the federal Health  
36 Care Financing Administration and the provisions of this section  
37 by means of an all-county letter or similar instruction to providers.  
38 Thereafter, the department shall adopt regulations to implement  
39 this section and the approved waiver in accordance with the  
40 requirements of Chapter 3.5 (commencing with Section 11340) of

1 Part 1 of Division 3 of Title 2 of the Government Code. Beginning  
2 six months after the effective date of the act adding this  
3 subdivision, the department shall provide a status report to the  
4 Legislature on a semiannual basis until regulations have been  
5 adopted.

6 (6) In the event that the Department of Finance determines that  
7 the program operated under the authority of the waiver described  
8 in paragraph (2) or the Family PACT successor state plan  
9 amendment is no longer cost effective, this subdivision shall  
10 become inoperative on the first day of the first month following  
11 the issuance of a 30-day notification of that determination in  
12 writing by the Department of Finance to the chairperson in each  
13 house that considers appropriations, the chairpersons of the  
14 committees, and the appropriate subcommittees in each house that  
15 considers the State Budget, and the Chairperson of the Joint  
16 Legislative Budget Committee.

17 (7) If this subdivision ceases to be operative, all persons who  
18 have received or are eligible to receive comprehensive clinical  
19 family planning services pursuant to the waiver described in  
20 paragraph (2) shall receive family planning services under the  
21 Medi-Cal program pursuant to subdivision (n) if they are otherwise  
22 eligible for Medi-Cal with no share of cost, or shall receive  
23 comprehensive clinical family planning services under the program  
24 established in Division 24 (commencing with Section 24000) either  
25 if they are eligible for Medi-Cal with a share of cost or if they are  
26 otherwise eligible under Section 24003.

27 (8) For purposes of this subdivision, “comprehensive clinical  
28 family planning services” means the process of establishing  
29 objectives for the number and spacing of children, and selecting  
30 the means by which those objectives may be achieved. These  
31 means include a broad range of acceptable and effective methods  
32 and services to limit or enhance fertility, including contraceptive  
33 methods, federal Food and Drug Administration approved  
34 contraceptive drugs, devices, and supplies, natural family planning,  
35 abstinence methods, and basic, limited fertility management.  
36 Comprehensive clinical family planning services include, but are  
37 not limited to, preconception counseling, maternal and fetal health  
38 counseling, general reproductive health care, including diagnosis  
39 and treatment of infections and conditions, including cancer, that  
40 threaten reproductive capability, medical family planning treatment

1 and procedures, including supplies and followup, and  
2 informational, counseling, and educational services.  
3 Comprehensive clinical family planning services shall not include  
4 abortion, pregnancy testing solely for the purposes of referral for  
5 abortion or services ancillary to abortions, or pregnancy care that  
6 is not incident to the diagnosis of pregnancy. Comprehensive  
7 clinical family planning services shall be subject to utilization  
8 control and include all of the following:

9 (A) Family planning related services and male and female  
10 sterilization. Family planning services for men and women shall  
11 include emergency services and services for complications directly  
12 related to the contraceptive method, federal Food and Drug  
13 Administration approved contraceptive drugs, devices, and  
14 supplies, and followup, consultation, and referral services, as  
15 indicated, which may require treatment authorization requests.

16 (B) All United States Department of Agriculture, federal Food  
17 and Drug Administration approved contraceptive drugs, devices,  
18 and supplies that are in keeping with current standards of practice  
19 and from which the individual may choose.

20 (C) Culturally and linguistically appropriate health education  
21 and counseling services, including informed consent, that include  
22 all of the following:

23 (i) Psychosocial and medical aspects of contraception.

24 (ii) Sexuality.

25 (iii) Fertility.

26 (iv) Pregnancy.

27 (v) Parenthood.

28 (vi) Infertility.

29 (vii) Reproductive health care.

30 (viii) Preconception and nutrition counseling.

31 (ix) Prevention and treatment of sexually transmitted infection.

32 (x) Use of contraceptive methods, federal Food and Drug  
33 Administration approved contraceptive drugs, devices, and  
34 supplies.

35 (xi) Possible contraceptive consequences and followup.

36 (xii) Interpersonal communication and negotiation of  
37 relationships to assist individuals and couples in effective  
38 contraceptive method use and planning families.

39 (D) A comprehensive health history, updated at the next periodic  
40 visit (between 11 and 24 months after initial examination) that

1 includes a complete obstetrical history, gynecological history,  
2 contraceptive history, personal medical history, health risk factors,  
3 and family health history, including genetic or hereditary  
4 conditions.

5 (E) A complete physical examination on initial and subsequent  
6 periodic visits.

7 (F) Services, drugs, devices, and supplies deemed by the federal  
8 Centers for Medicare and Medicaid Services to be appropriate for  
9 inclusion in the program.

10 (9) In order to maximize the availability of federal financial  
11 participation under this subdivision, the director shall have the  
12 discretion to implement the Family PACT successor state plan  
13 amendment retroactively to July 1, 2010.

14 (ab) (1) Purchase of prescribed enteral nutrition products is  
15 covered, subject to the Medi-Cal list of enteral nutrition products  
16 and utilization controls.

17 (2) Purchase of enteral nutrition products is limited to those  
18 products to be administered through a feeding tube, including, but  
19 not limited to, a gastric, nasogastric, or jejunostomy tube.  
20 Beneficiaries under the Early and Periodic Screening, Diagnosis,  
21 and Treatment Program shall be exempt from this paragraph.

22 (3) Notwithstanding paragraph (2), the department may deem  
23 an enteral nutrition ~~product~~, *product* not administered through a  
24 feeding tube, including, but not limited to, a gastric, nasogastric,  
25 or jejunostomy tube, a benefit for patients with diagnoses,  
26 including, but not limited to, malabsorption and inborn errors of  
27 metabolism, if the product has been shown to be neither  
28 investigational nor experimental when used as part of a therapeutic  
29 regimen to prevent serious disability or death.

30 (4) Notwithstanding Chapter 3.5 (commencing with Section  
31 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
32 the department may implement the amendments to this subdivision  
33 made by the act that added this paragraph by means of all-county  
34 letters, provider bulletins, or similar instructions, without taking  
35 regulatory action.

36 (5) The amendments made to this subdivision by the act that  
37 added this paragraph shall be implemented June 1, 2011, or on the  
38 first day of the first calendar month following 60 days after the  
39 date the department secures all necessary federal approvals to  
40 implement this section, whichever is later.

- 1 (ac) Diabetic testing supplies are covered when provided by a
- 2 pharmacy, subject to utilization controls.

O